DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

School Year 2013-2014 Student Enrollment Information

April 2013

1200 First Street, NE | Washington, DC 20002 | T 202.442.5885 | F 202.442.5026 | dcps.dc.gov

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

April 1, 2013

ENROLLMENT PACKET FOR 2013-2014

- If your child is attending a new DCPS school, please return enrollment forms to the **NEW SCHOOL** by Thursday, June 20, 2013.
- If your child received a seat through the Preschool, Pre-K, Out-of-Boundary Lottery or High School Online Application for SY 2013-2014, please return enrollment forms to the **NEW SCHOOL** by May 1, 2013.

Dear Families,

Enclosed you will find the materials necessary to enroll your child in the District of Columbia Public Schools (DCPS) for the 2013-2014 school year. Please carefully review all the enclosed materials. Complete and return all forms including this checklist – to your child's current or new school as soon as possible to secure your child's spot at his/her school.

Important Enrollment Dates

- April 1: Enrollment begins
- May 1: All enrollment packet materials due for families who applied in the Preschool, Pre-K, Out-of-Boundary (OOB) lottery and the High School Online Application
- June 20: Deadline for Enrollment (all forms must be returned to your child's school)

Student Enrollment Forms

- **The Annual Student Enrollment Form has been printed to include your child's previously submitted information.** If the information included has changed or is incorrect, please make changes directly on the form and review with your school's principal/registrar.
- You can locate all documents online at www.dcps.dc.gov/enroll. (Translations are available in Spanish, French, Chinese, Vietnamese, Amharic and Korean)
- **For a listing of feeder school options to help you identify your child's new school, visit** www.dcps.dc.gov/enroll.

If you have any questions about completing your enrollment packet, please do not hesitate to contact your child's school directly or the Critical Response Team at **202-478-5738.**

DCPS Enrollment Checklist for 2013-2014

* = Mandatory for new and returning families to complete		Parent/Guardian Initials	School Official Initials
1	**Annual Student Enrollment Profile (including resident verification at school)***		
2	**Residency Verification (form is available at your child's school)***		
3	**Home Language Survey***		
4	**FERPA Notification***		
5	**Media Release**		
6	**Student Health Checklist***		

_____ _____

Parent/Guardian Signature and Date School Official Signature and Date

Notice of Non-Discrimination *In accordance with state and federal laws, the District of Columbia Public Schools does not discriminate on the basis of actual or perceived race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, gender identity or expression, family status, family responsibilities, matriculation, political affiliation, genetic information, disability, source of income, status as a victim of an interfamily offense, or place of residence or business. For the full text and additional information, visit http://dcps.dc.gov/DCPS/About+DCPS/Human+Resources/Notice+of+Non-Discrimination.*

****** This checklist should be retained at the local school. ******

DISTRICT OF COLUMBIA PUBLIC SCHOOLS

ANNUAL STUDENT ENROLLMENT PROFILE
School Year 2013 - 2014

Grade in School Year 2013 - 2014: ☐ **School in SY 2013 - 2014:** _____

DCPS Student ID #: _____ **(Print all information)**

STUDENT INFORMATION

1. Last Name	2. First Name	3. Middle Name	4. Country of Birth	5. Date of Birth

6. Address	7. Apt. No.	8. Home Telephone Number

9. City	10. State	11. ZIP Code

12. Student's Gender: ☐ Male ☐ Female ☐ Decline to Respond

13. Student's Home Language(s) :

14. School Last Attended:	Dates Attended:	Previous School Address:		
☐ Private ☐ Public ☐ Charter ☐ Other	Month/Date/Year _____ - _____	City	State	Zip Code

15. Health Insurance or Medicaid Information
Provider: _____ Policy Number: _____
List any medical conditions of which the school should be aware.

For students new to DCPS, please indicate whether or not your child has a(n):
IEP (Individualized Education Program) **Y☐ or N☐** If yes, IEP review date: _____
Section 504 Accommodation Plan **Y☐ or N☐**

16. Student's Siblings	A.	B.	C.
Student's Siblings' Schools			

17. Ethnic Designation:
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

17b. Race - choose one or more
☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander
☐ American Indian/Alaska Native ☐ Asian ☐ White

PARENT/GUARDIAN INFORMATION AND OTHER PRIMARY CAREGIVER INFORMATION*

18. Parent or Guardian	Relationship	☐ Active Military ☐ Reserve Military	19. Parent or Guardian	Relationship	☐ Active Military ☐ Reserve Military

Address	Apt. No.	Address	Apt. No.

City	State	ZIP Code	City	State	ZIP Code

Email Address	Preferred Language of Communication	Email Address	Preferred Language of Communication

Cell Number	Work Number	Cell Number	Work Number

Employer's Name/Address	Employer's Name/Address

City	State	ZIP Code	City	State	ZIP Code

EMAIL AND TEXT COMMUNICATION*

20. ☐ I would like to receive email messages from my child's principal and DC Public Schools at the address listed above OR the address listed below.
Email address: @

☐ I would like to receive text messages from DC Public Schools at the number listed above OR the number listed below. I understand standard messaging and data rates may apply. cell phone number: ( )

IN CASE OF EMERGENCY

21. Emergency Contact Person (other than parent/guardian)	Relationship	Home Number ( )	Work Number ( )

Address	City	State	Zip Code	Cell Number ( )

RESIDENCY STATUS (CHECK ONE ☑)

22. ☐ D.C. Resident (Student and parent or guardian live in D.C.) ☐ Nonresident

HOUSING STATUS (CHECK ONE ☑)

23. ☐ Permanent	☐	Hotel/Motel	☐	Unaccompanied Youth	☐	Other Temporary Housing
☐ Shelter	☐	Awaiting Foster Care	☐	Shared Housing	☐	Foster Care

** DCPS agrees that the data/ information provided in the Student Enrollment Profile shall remain confidential and shall only be used for legitimate DCPS business.*

I completed this form and I certify that the information above is accurate. I understand that providing false information for purposes of defrauding the government is punishable by law.

_____ _____

***Signature of Parent/ Guardian with Whom Student Lives or Student Who is 18 or Older.** **Date**

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

RESIDENCY VERIFICATION GUIDELINES

Every school year, parents/guardians and other primary caregivers are required to verify residency for every registering student. The following guidelines provide a comprehensive view of the required documentation for proving residency in the District of Columbia for school year 2013-2014.

Other primary caregivers are also required to present documentation attesting to their eligibility to enroll and verify residency for a student. Check with your local school for a listing of required documents.

Procedures for the Establishment of Residency

- Establish residency by Oct. 5, 2013, or within 10 days of the time of initial enrollment, whichever occurs later in the school year. This verification shall take place no sooner than April 1 of the current school year (April 1, 2013).
- Provide *original documents* to the school representative as proof of residency. Schools are required by law to copy your original documents for audit purposes.
- A parent/guardian/caregiver can opt out of making copies of required residency documents. Your child's registrar can give you the official Opt-Out form. Residency documents may have to be presented upon request during the official enrollment audit.
- **New for school year 2013-2014:** The residency verification form must be signed by the same parent/guardian/caregiver whose residency documents are submitted at the time of enrollment**.**

Residency status shall be established through the use of satisfactory documentation as provided in requirements (1) or (2) below. **Substitutions will not be accepted at the local school level for any of the documents listed.** A full description of residency documents listed below can be found at www.dcps.dc.gov/enroll.

REQUIREMENTS FOR PROVING RESIDENCY (OPTION 1)

***One of the following items* indicating name and address will suffice to establish District of Columbia residency:**	
1. A **pay stub issued within 45 days, with your DC Address and DC tax withholding**	5. Proof of **financial assistance from the DC government**
2. **Supplemental Security Income annual benefits notification**	6. A **tax information authorization waiver form** certified by the DC office of Tax and Revenue
3. **Verification Letter** *and* **Military Housing Orders;** or **DEERS Statement**	7. Proof that the child is a **ward of the District of Columbia**, in the form of a **Court Order**
4. An **embassy letter** indicating embassy sponsored housing in DC, embassy seal affixed	

REQUIREMENTS FOR PROVING RESIDENCY (OPTION 2)

***In the absence of items listed in Option 1, two (2) of the items listed below indicating name and address* will suffice as proof of residency in the District of Columbia. The address and name on each submitted item must be the same.**	
1. Unexpired **DC motor vehicle registration**	3. Unexpired **lease or rental agreement with receipt of payment** within 2 months
2. Unexpired **DC motor vehicle operator's** 3. **permit** or their official non-driver identification	4. **One utility bill** (only gas, electric and water bills are acceptable) **with receipt of payment** within 2 months

Documents shown on the Residency Verification Form and in these guidelines are acceptable for proving DC residency. Alternative documentation may be accepted on a case-by-case basis in the DCPS Student Residency Office only, located at 1200 First St. NE, 9th Floor. Call for an appointment (202) 442-5215.

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS
Office of the Chief Academic Officer

DCPS Home Language Survey (HLS) Form

Complete this Home Language Survey at the Student's initial enrollment in a DC Public School.

This form must be signed and dated by the Parent or Guardian. This form must be kept in the student's file.

School: _____ **Student ID #:** _____

Student's Last Name: _____ **Student's First Name**_____

English

1. **Is a language other than English spoken in your home?**
   ☐ **No** ☐ **Yes** _____ **(specify language)**
2. **Does your child communicate in a language other than English?**
   ☐ **No** ☐ **Yes** _____ **(specify language)**
3. **What is your relationship to the child?**
   ☐ **Father** ☐ **Mother** ☐ **Guardian** ☐ **Other (specify)**_____

If the answer to question 1 or 2 is Yes, the law requires your child's English language proficiency to be assessed.

REGISTRAR PROCESS:

- If a parent/guardian does not speak English and your school does not have staff that speaks the parent/guardian's language, please use the Language Line for communication.
- If the HLS indicates a language other than English is spoken in the home, give the family the OBE Referral Letter and refer the family to the OBE Intake Center for assessment and orientation.

Español (Spanish)

1. **¿Se habla otro idioma que no sea el inglés en su casa?**
   ☐ **No** ☐ **Sí** _____**(idioma)**
2. **¿Habla el estudiante un idioma que no sea el inglés?**
   ☐ **No** ☐ **Sí** _____**(idioma)**
3. **¿Cuál es su relación con el estudiante?**
   ☐ **Padre** ☐ **Madre** ☐ **Guardián** ☐ **Otro (especifique)**_____

Si la respuesta a la pregunta 1 ó 2 es "Sí", la ley requiere que se evalúe la fluidez de su hijo/a en el idioma inglés.

Français (French)

1. **Parlez-vous une langue autre que l'anglais à la maison ?**
   ☐ **Non** ☐ **Oui** _____ **(spécifiez la langue)**
2. **Votre enfant communique-t-il dans une langue autre que l'anglais ?**
   ☐ **Non** ☐ **Oui** _____ **(spécifiez la langue)**
3. **Quel est votre relation avec l'enfant ?**
   ☐ **Père** ☐ **Mère** ☐ **Tuteur** ☐ **Autre (spécifiez)** _____

Si la réponse à la question 1 ou 2 est Oui, la loi exige que les compétences de votre enfant en anglais soit évaluées.

中文 (Chinese)

1. 您家庭中是否使用不是英语的另外一种语言?
   ☐ 否 ☐ 是 _____ (请指明语言)
2. 您的孩子会使用不是英语的另一种语言交流吗?
   ☐ 不会 ☐ 会 _____ (请指明语言)
3. 您和孩子的关系是什么?
   ☐ 父亲 ☐ 母亲 ☐监护人 ☐其它(请指明) _____

如果第一或第二项问题的答案为"是"，法律要求评估您孩子的英语熟练能力（English language proficiency）。

Tiếng Việt (Vietnamese)

1. **Có ngôn ngữ nào khác ngoài tiếng Anh được nói ở nhà quý vị không?**
   ☐ **Không** ☐ **Có** _____ **(xin ghi rõ ngôn ngữ nào)**
2. **Con em quý vị có nói một ngôn ngữ nào khác ngoài tiếng Anh không?**
   ☐ **Không** ☐ **Có** _____ **(xin ghi rõ ngôn ngữ nào)**
3. **Xin cho biết liên hệ của quý vị với con em?**
   ☐ **Cha** ☐ **Mẹ** ☐ **Giám hộ** ☐ **Liên hệ khác (xin ghi rõ)**

_____

Nếu trả lời của câu hỏi 1 hoặc 2 là Có, luật lệ đòi hỏi con em quý vị phải được thẩm định trình độ thông thạo Anh ngữ.

አማርኛ (Amharic)

1. በቤትዎ ውስጥ ከእንገሊዘኛ ሌላ የሚነገር ቋንቋ አለ ?
   ☐ የለም ☐ አዎን _____(ቋንቋውን ይጥቀሱ)
2. ልጅዎ ከእንገሊዘኛ ሌላ የሚነጋገርብት ሌላ ቋንቋ አለ?
   ☐ የለም ☐ አዎን _____(ቋንቋውን ይጥቀሱ)
3. ለልጁ ያለዎት ዝምድና ምንድን ነው?
   ☐ አባት ☐ እናት ☐ አሳዳጊ ☐ ሌላ_____ (ይግለጹ)

ለጥያቄ 1 ወይም 2 መልስዎ አዎን ከሆነ፥ የልጅዎ የእንገሊዘኛ ቋንቋ ቅልጥፍና ችሎታው ደረጃ እንዲገመገም ህጉ ያዛል።

School Official's Comments:

_____ _____

Signature of School Official **Date** **Signature of Parent/Guardian** **Date**

DISTRICT OF COLUMBIA
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Notification of Rights under FERPA

The Family Educational Rights and Privacy Act (FERPA) affords parents and students age 18 or older ("eligible students") certain rights with respect to the student's education records. These rights are:

(1) The right to inspect and review the student's education records within 45 days of the day the District of Columbia Public Schools (DCPS) receives a request for access. Parents or eligible students should submit to the school principal a written request that identifies the record(s) they wish to inspect. The school principal or other appropriate school official will make arrangements for access and notify the parent or eligible student of the time and place where the records may be inspected.

(2) The right to request amendment of the student's education records that the parent or eligible student believes are inaccurate, misleading or otherwise in violation of the student's privacy rights under FERPA. Parents or eligible students may write the school principal, clearly identify the part of the record they want changed, and specify why it should be changed. If DCPS decides not to amend the record as requested by the parent or eligible student, the school will notify the parent or eligible student of the decision and advise them of their right to a hearing regarding the request for amendment. Additional information regarding the hearing procedures will be provided to the parent or eligible student when notified of the right to a hearing.

(3) The right to consent (in writing) to disclosures of personally identifiable information contained in the student's education records, except to the extent that FERPA authorizes disclosure without consent. For example, FERPA authorizes disclosure without consent to school officials whom DCPS has determined to have legitimate educational interests. A school official is a person employed by DCPS as an administrator, supervisor, instructor, or support staff member (including health or medical staff and law enforcement unit personnel); a person or company with whom DCPS has contracted to perform a special task (such as an attorney, auditor, medical consultant, or therapist); an official of another school system where a student seeks or intends to enroll, or where the student is already enrolled; or a parent, student or other volunteer serving on an official committee, such as a disciplinary or grievance committee, or assisting another school official in performing his or her tasks. A school official has a legitimate educational interest if the official needs to review an education record in order to fulfill his or her professional responsibility.

(4) The right to withhold disclosure of directory information. At its discretion, DCPS may disclose basic "directory information" that is generally not considered harmful or an invasion of privacy without the consent of parents or eligible students in accordance with the provisions of District law and FERPA. Directory information includes:

A. Student Name
B. Student Address
C. Student Telephone Listing
D. Name of School Attending
E. Participation in Officially Recognized Activities and Sports
F. Weight and Height of Members of Athletic Teams
G. Diplomas and Awards Received
H. Student's Date and Place of Birth
I. Names of Schools Previously Attended
J. Dates of Attendance

Parents or eligible students may instruct DCPS to withhold any or all of the information identified above (i) by completing the "Release of Student Directory Information" Form available at www.dcps.dc.gov/enroll or the local school, or (ii) by providing notice in writing to the Office of Data and Accountability at 1200 First St. NE, 12th Floor, Washington, DC 20002. The release or notification must be provided within 30 days of the issuance of this notice.

(5) The right to file a complaint with the U.S. Department of Education concerning alleged failures by DCPS to comply with the requirements of FERPA. The name and address of the office that administers FERPA are: Family Policy Compliance Office, U.S. Department of Education, 400 Maryland Ave. SW, Washington, DC 20202.

DISTRICT OF COLUMBIA
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CONSENT AND RELEASE FOR STUDENTS TO BE FILMED/ PHOTOGRAPHED/ INTERVIEWED AND FOR USE OF IMAGE/VOICE

I, _____, hereby irrevocably grant to District of Columbia Public
Parent/Guardian's Name
Schools (DCPS) and the District of Columbia , their successors, and their assignees the right to record the image and/or voice and use the artwork and /or written work of my child, _____,
Child's Name
on videotape, on film, in photographs, in digital media and in any other form of electronic or print medium and to edit such recording at their discretion.

I understand that my child's full name, address and biographical information will not be made public. I further grant District of Columbia Public Schools (DCPS) and the District of Columbia , their successors, and their assignees the right to use, and to allow others to use, my child's image and/or voice on the internet, in brochures, and in any other medium and hereby consent to such use.

I hereby release District of Columbia Public Schools (DCPS) and the District of Columbia , their successors, and their assignees and anyone using my child's image and/or voice, artwork and/or written work pursuant to this release from any and all claims, damages, liabilities, costs and expenses which I or my child now have or may hereafter have by reason of any use thereof.

I understand that the provisions of this release are legally binding.

_____
Parent/Guardian (if student is under 18) [Print Name]

_____
Signature Date

Student's School: _____ Student's Grade:_____

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Right to Opt Out of Release of Information to Military Recruiters
(Students in Grades 7–12 & Ungraded Students Only)

Federal laws require that local education agencies (LEAs) such as DCPS provide military recruiters, upon request, with the name, address, and telephone number of all secondary students unless the parent/legal guardian of a student (or the student if an adult) has advised the LEA in writing that he/she does not want the student's information disclosed without prior written consent. Such advisement by the parent/legal guardian (or adult student) must take place within 30 days of the notification of these rights, and may be done by checking one of the appropriate options below, signing this form and returning it to DCPS.

_____ As the parent/legal guardian for the child named below, I request that DCPS not release the name, address, and telephone number of my child to the Armed Services, military recruiters, service academies or military schools unless I separately consent to such release in writing.

_____ As an adult student (who has reached the age of 18), I request that DCPS not release my name, address, and telephone number to the Armed Services, military recruiters, service academies or military schools unless I separately consent to such release in writing.

Student's Name Printed	Signature of Parent/Legal Guardian or Student (if an adult)	Date

Notice of Non-Discrimination *In accordance with state and federal laws, the District of Columbia Public Schools does not discriminate on the basis of actual or perceived race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, gender identity or expression, family status, family responsibilities, matriculation, political affiliation, genetic information, disability, source of income, status as a victim of an interfamily offense, or place of residence or business. For the full text and additional information, visit http://dcps.dc.gov/DCPS/About+DCPS/Human+Resources/Notice+of+Non-Discrimination.*

How to Apply for Free and Reduced Meals

The Family Application for Free and Reduced Meals (FARM) will be available in July 2013. **Parents/Guardians must submit the FARM application to determine if their child qualifies for free lunches**. Students who qualify for "reduced" meals will not pay for school lunches. Breakfast and supper (where provided) are universally free.

Your child's school will distribute paper copies of the application when the new application is available. The form is not located in this enrollment packet. When the paper form is released, an electronic form will be also available online at the following link: http://dcps.dc.gov/DCPS/FARM

We encourage families to complete this form online.

Certain DCPS schools will serve all meals for free and will not require the submission of FARM applications because the USDA has certified these schools for the Community Eligibility Option. Schools will notify parents/guardians if they do not need to complete the FARM application.

How to Pay for School Meals

Parents/Guardians of students who do not qualify for free or reduce meals can pay for all meals with a valid credit or debit card at the website *MyLunchMoney.com*, a secure online payment system. In addition, prepayments can be made via cash or check, (made payable to the DC Treasury), at the student's cafeteria. Schools that do not qualify for the Community Eligibility Option have cashless kiosks available in the cafeteria for students or parents/guardians to deposit cash directly into their account. Meal prices and policies can be found on the food services website.

Allergies and Accommodations

Visit http://dcps.gov/DCPS/foodaccommodations to download the "Religious/Philosophical Dietary Accommodations Application" to register special dietary needs including food intolerances and allergies. For students with allergies, **the form must be completed and signed by a licensed medical provider at the start of every school year.** Submit the form to the school nurse. A copy will be kept on file at the school.

DISTRICT OF COLUMBIA PUBLIC SCHOOLS

School Health Checklist, School Year 2013-2014

Please turn in the following forms to the **Registrar** at your child's school when you enroll your child. DC law requires that **all students** be current on immunizations to attend school. DC law also requires Universal Health Certificates for children enrolling in all grades and Oral Health Assessments for children in selected grades.

Form	Description	Required	Notes
Universal Health Certificate	Two-page form, and two-page instructions for your medical provider	Students enrolling in all grades (Preschool-12th).	Have your child's physician or nurse practitioner complete the Universal Health Certificate Form. The Universal Health Certificate must document immunizations, tuberculosis assessment and physical completed within 365 days before the start of school. Children in Early Childhood Programs, and older than 26 months up to 6 years old who have not yet been tested for lead exposure also need lead screening documented on the Universal Health Certificate. If your child participates in athletics, the certificate will expire 365 days from the date of the exam listed on the form. To remain eligible for athletics, an updated Universal Health Certificate must be submitted to the school when a new physical occurs. (Need health insurance? Visit http://dhcf.dc.gov/service/dc-healthy-families)
Immunization Documentation	Age-appropriate immunizations must be documented on the Universal Health Certificate. A one-page flier of required immunizations is included.	Students enrolling in all grades (Preschool – 12th). After 10 days of school, students who have not submitted their immunizations will be excluded from classes and supervised separately.	Please schedule a visit with your child's physician soon if your child's immunizations are not up to date. Some immunizations require more than one dose with return visits. If you have questions about DC's immunization requirements, please discuss them with your child's physician. You can also contact the DC Department of Health Immunization Division at 202-576-9325.
Oral Health Assessment Form	One-page, and one-page instructions for dentist	Students entering grades Preschool, Pre-K, K, 1, 3, 5, 7, 9 and 11.	Have your child's dentist complete this form. (Have Medicaid, but need help finding a dental provider or making an appointment? Call 1-866-758-6807 or visit http://www.insurekidsnow.gov/state/dc/district_oral.html) (Need dental insurance? http://dhcf.dc.gov/service/dc-healthy-families)
HPV Vaccine Refusal Form	Included is an HPV vaccine-refusal form and an explanation of the vaccine (2 pages)	Male and female students in grades 6-10.	If you decide your child (male or female) in grades 6-10 will not get the HPV vaccine, please turn in the HPV vaccine-refusal form. If you need to file an exemption for other vaccines, please contact your child's school nurse.
Medication Orders	There are required forms in order for the school to meet your child's medication or medical intervention needs. You can get these forms from your school nurse or online at: www.dcps.dc.gov	Students who need medication or medical intervention during the school day, for asthma, allergies, diabetes, seizures, or other medical conditions. If this applies to your child, please speak with your principal and nurse about your child's physical health or behavioral health condition and intervention requirements.	Students who are allowed to self-administer medications for asthma, anaphylaxis, or diabetes while at school must also have a medication action plan signed by the student's parent or guardian, and physician.

If you have any questions, please feel free to contact Diana Bruce, DCPS Director of Health and Wellness: 202-442-5103 or Diana.Bruce@dc.gov. You can find copies of these forms on the DCPS website.

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 1: Child's Personal Information

Parent/Guardian: *Please complete Part 1 clearly and completely & sign Part 5 below.*

Child's Last Name:	*Child's First & Middle Name:*	*Date of Birth:*	*Gender:* ☐ *M* ☐ *F*	*Race/Ethnicity:* ☐ *White Non Hispanic* ☐ *Black Non Hispanic* ☐ *Hispanic* ☐ *Asian or Pacific Islander* ☐ *Other*_____
Parent or Guardian Name:	*Telephone:* ☐ *Home* ☐ *Cell* ☐ *Work*	*Home Address:*		*Ward:*
Emergency Contact Person:	*Emergency Number:* ☐ *Home* ☐ *Cell* ☐ *Work*	*City/State (if other than D.C.)*		*Zip code:*
School or Child Care Facility:	☐ *Medicaid* ☐ *Private Insurance* ☐ *None* ☐ *Other* _____	*Primary Care Provider (PCP):*		

Part 2: Child's Health History, Examination & Recommendations

Health Provider: Form must be fully completed.

DATE OF HEALTH EXAM:	WT ☐ LBS ☐ KG	HT ☐ IN ☐ CM	BP: (>3 yrs) ☐ NML ☐ ABNL	Body Mass Index (>2 yrs) (BMI)_____ %_____
HGB / HCT *(Required for Head Start)*	Vision Screening ☐ Glasses ☐ Referred Right 20/____ Left 20/____		Hearing Screening Pass_____ Fail_____ ☐ Referred	

HEALTH CONCERNS:			REFERRED or TREATED	HEALTH CONCERNS:			REFERRED or TREATED
Asthma	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Language/Speech	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Seizure	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Development/ Behavioral	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Diabetes	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Other_____	☐ NONE	☐ YES	☐ Referred ☐ Under Rx

ANNUAL DENTIST VISIT: (Age 3 and older): Has the child seen a Dentist/Dental Provider within the last year? ☐ YES ☐ NO ☐ Referred

A. Significant health history, conditions, communicable illness, or restrictions that may affect school, child care, sports, or camp.
☐ NONE ☐ YES, please detail:

_____

_____

B. Significant food/medication/environmental allergies that may require *emergency medical care* at school, child care, camp, or sports activity.
☐ NONE ☐ YES, please detail: _____

_____

C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements.
☐ NONE ☐ YES, please detail (For any medications or treatment required during school hours, a Physician's Medication Authorization Order should be submitted with this form)

_____

_____

_____

Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing:

TB RISK ASSESSMENTS	☐ HIGH→ ☐ LOW	Tuberculin Skin Test (TST) DATE:	☐ NEGATIVE ☐ POSITIVE	If **TST** Positive ☐ CXR NEGATIVE ☐ CXR POSITIVE ☐ TREATED	**Health Provider:** POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: 202-698-4040
LEAD EXPOSURE RISKS	☐ YES→ ☐ NO	LEAD TEST DATE:	RESULT:	**Health Provider:** *ALL* lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: Fax: 202-481-3770	

Part 4: Required Provider Certification and Signature

☐ YES ☐ NO This child has been appropriately examined & health history reviewed. At time of exam, this child is in satisfactory health to participate in all school, camp or child care activities except as noted above.

☐ YES ☐ NO This athlete is cleared for competitive sports.

☐ YES ☐ NO Age-appropriate health screening requirements performed within current year. If no, please explain:

_____

_____

Print Name	MD/NP Signature	Date
Address	Phone	Fax

Part 5: Required Parental/Guardian Signatures. (Release of Health Information)

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government Agency.

Print Name **Signature** **Date**

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Student's Name: _____/_____/_____ Date of Birth:_____/_____/_____
Last First Middle Mo. /Day/ Yr.

Sex: ☐ Male ☐ Female School or Child Care Facility:_____

Section 1: Immunization: Please fill in or attach equivalent copy with provider signature and date.

IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN						
Diphtheria,Tetanus, Pertussis (DTP,DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Chicken Pox Disease History: Yes ☐ When: Month_____ Year_____ Verified by:_____ (Health Care Provider) Name & Title				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1						
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Other							

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date

Section 2: MEDICAL EXEMPTION. For Health Care Provider Use Only.

I certify that the above student has a valid medical contraindication to being immunized at the time against: (check all that apply)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

Reason:_____

This is a permanent condition (___) or temporary condition (___) until ____/____/____.

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date

Section 3: Alternative Proof of Immunity. To be completed by Health Care Provider or Health Official.

I certify that the student named above has laboratory evidence of immunity: (Check all that apply & attach a copy of titer results)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE INSTRUCTIONS

This form r*eplaces a*ll forms dated before February 24, 2009. This District of Columbia Universal Health Certificate (DCUHC) will be used for entry into Child Care Facilities, Head Start and DC public, private and parochial schools.
Exception: It cannot be used to replace EPSDT forms or the Department of Health Oral Health Assessment Form. The DCUHC was developed by the DC Department of Health and follows the American Academy of Pediatrics (AAP) guidelines for child and adolescent preventive health care; from birth to 21 years of age. **This form is a confidential document,** consistent with the requirements of the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) for health providers, and *the Family Educational Rights and Privacy Act of 1974* (FERPA) for educational institutions.

General Instructions: Please use a black ball point pen when completing this form.

Part 1: Child's Personal Information:
Parent or Guardian: Please complete all of your child's personal information including the child's last name, first and middle name, date of birth and gender. Also include your name, phone number, home address, the ward in which the address is located, and the name and phone number of an emergency contact in case you cannot be reached. Provide the name of the school or child care facility. Check the box that describes your child's type of health insurance coverage. If the child's type of insurance coverage is not listed, check "other" and write the type of coverage in the space provided. Write the name of your child's primary care provider (doctor). If your child does not have a primary care provider, write "none" in the space provided. **This form will not be complete without the parent or guardian's signature in Part 5.**

Part 2: Child's Health History, Examination & Recommendations: (To be completed by the health care provider). Please mark all relevant boxes.

- **Date of Health Exam**: All children must have a physical examination by a physician or certified nurse practitioner as per the AAP Guidelines. The date entered here must indicate the date of the examination.
- **WT:** Child's weight in either pounds (LBS) or kilograms (KG); **HT:** Child's height in either inches (IN) or centimeters (CM).
- **BP:** If a child is three years of age or older, write the blood pressure value in the box and check if normal or abnormal. If abnormal, provide an explanation and resolution in Part 2: Section A.
- **Body Mass Index (BMI):** If the child is 2 years of age or older, the BMI has to be calculated and recorded inclusive of percentile.
- **HGB/HCT:** Hemoglobin (HGB) or Hematocrit (HCT) is ***required* for Head Start children**. Also, anemia screening is recommended for menstruating adolescents based on AAP guidelines. Please record blood level and indicate which test was performed by circling HGB, HCT or both.
- **HEALTH CONCERNS:** The health care provider must perform the following health screens: asthma, seizure, diabetes, language, developmental/behavioral and other disorders that may require special health care needs." For any of the health screens where there are "HEALTH CONCERNS," the health care provider must check the box indicating that the proper referral has been made or the child is currently being treated (Rx) for the concern. IF there are NO/NONE "HEALTH CONCERNS", then check the **'NO" or None"** box in each health screening area.
- **SPECIAL NOTE:** "Annual Dentist Visit" – for children three years of age and older, the health care provider must indicate whether a dentist has screened or examined the child within the last 12 months. If "No", the child should be referred to a dentist.
- **A:** Please note any significant health history, conditions, communicable illness and restrictions that may affect the child's ability to perform in a school-related activity or program or mark "NONE"**.**
- **B:** Please note any significant allergies that may require ***emergency medical care*** at a school-related activity or program or mark "NONE"**.**
- **C:** Please note any long-term medications, over-the-counter drugs or special care requirements at a school-related activity or program or mark
- "NONE"**.**
- **SPECIAL NOTE:** Please note any medications or treatments required at a school-related activity or program in Part 2: Section C and complete a Physician's Medication Authorization Order and attached it to the health certificate.

Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing:

• **TUBERCULOSIS (TB) RISK ASSESSMENT:** Perform risk assessment for TB as defined by the *AAP Tuberculin Skin Test Recommendations for Infants, Children and Adolescents in the 2006 AAP RED BOOK, 27th Ed., page 682*. Current DC regulations require one TST (Tuberculin Skin Test) for all children entering child care or school; whichever comes first. TST is also required for all children who are assessed as **HIGH RISK OF EXPOSURE.** Please note the test and mark the test outcome (negative or positive). **If the TST is positive,** then mark the chest X-Ray outcome (CXR) and whether the child was treated. **All positive TSTs must be reported to the DC T.B. Control Program on 202-698-4040.**
• **LEAD EXPOSURE RISKS:** DC law requires that all children are tested between 6 and 14 months of age and again between 22 and 26 months. DC law also requires that if a child is more than 26 months old and has not yet been tested for lead exposure, that child must be screened twice prior to age 6. Please document both the "Date" and "Result" of most recent lead test. Please indicate if "Pending." "Pending" results will be **valid for two months from date of testing** and will not exclude a child from school-related activity or program. **ALL lead tests must be reported electronically by labs to the DC Childhood Lead Poisoning Prevention Program. For detailed instructions, call 202-654-6036/6037**. **Providers may fax results to: 202-481-3770.**

Part 4: Required Provider (physician or nurse practitioner) Certification and Signature:
The provider will respond by marking "Yes" or "No" to the following statements:
The child was appropriately examined with a review of the health history;
The child is cleared for competitive sports (based on the assessment and consistent with the AAP Pre-participation Physical Evaluation 2nd Ed. (1997; and The child has received age-appropriate screenings (in accordance with AAP and EPSDT guidelines) within the current year. If "No" is marked, explain the reason in the space provided. All information will be kept confidential.

Part 5: Required Parent/Guardian Signatures. (Release of Health Information).
The parent or guardian must print their name; provide a signature and the date. By signing this section the parent or guardian gives permission to the health provider to share the health information on this form with the child's school, child care facility, camp or appropriate DC Government agency.

Forms are available online at www.doh.dc.gov

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 6: IMMUNIZATION INFORMATION

General Instructions: Please use black ball point pen when completing form

Child/Student Personal Information: Print clearly child/students last name, first name, and middle name/initial. Enter date of birth as mm/dd/yr. Indicate sex of child/student by checking female or male. Indicate name of school or child care facility child attends.

Section 1: Immunization Information – Enter clearly date (mm/dd/yy) vaccine(s) administered or attach equivalent copy with provider's signature and date. As required by D.C. Law 3-20, "Immunization of School Students Act of 1979" and DCMR Title 22, Chapter 1 (revised May 2, 2008), the following immunizations are required.

Instructions: Find the age of the child/student in the column labeled "Child's Current Age". Read across the row for each required vaccine. The number in the box is the number of doses required for that vaccine based on the CURRENT age or grade level of the child. The age range in the column does not mean that the child has until the highest age in that range to meet compliance. Any child whose age falls within that range must have received the required number of doses based on his/her CURRENT age in order to be in compliance.

Vaccine types and dosage numbers required for children enrolled in Child Care Programs[1, 2]

Child's Current Age	DTaP/DTP/DT	Polio	Hib[7]	MMR[8]	Varicella[9] (Chickenpox)	Hepatitis B[10]	Hepatitis A[11]	Pneumococcal Conjugate[12]	Meningococcal	Human Papillomavirus (HPV)
Less than 2 months	0	0	0	0	0	1	0	0	0	0
2 – 3 months	1	1	1	0	0	1	0	1	0	0
4 – 5 months	2	2	2	0	0	2	0	2	0	0
6 – 11 months	3	3	2 / 3	0	0	3	0	3	0	0
12 – 14 months	3	3	3 / 4	1	1	3	1	4	0	0
15 – 23 months	4	3	3 / 4	1	1	3	1	4	0	0
24 – 47 months	4	3	3 / 4	1	1	3	2	4	0	0
48 – 59 months	5[3]	4[6]	3 / 4	2	2	3	2	4	0	0

Vaccine types and dosage numbers required for children enrolled in Public, Charter, Parochial and Private Schools[1, 2]

Grade Level		DTaP/DTP/DT/ Td/Tdap	Polio[6]	Hib	MMR[8]	Varicella[9] (Chickenpox)	Hepatitis B[10]	Hepatitis A[11]	Pneumococcal Conjugate	Meningococcal[13]	Human Papillomavirus[14] (HPV)
Grade	(Ungraded)										
Grades K – 5	(5 – 10 yrs)	5[3, 4]	4	0	2	2	3	2	0	0	0
Grades 6 - 12	(11 – 18+ yrs)	6[4, 5]	4	0	2	2	3	2	0	1	3

[1]Spacing: Doses must be appropriately spaced and given at appropriate age. Vaccine doses administered up to 4 days before minimum interval or age are counted as valid. Exception: Two live virus vaccines that are not administered on same day, must be separated by a minimum of 28 days.

[2]Exemptions: Medical exemptions from immunizations may be granted for valid reasons with proper documentation from health care provider (Section 2). Blood titers may be obtained in lieu of immunizations (Section 3). A copy of the lab report must be submitted to school/child care facility. Documentation for religious exemptions must be submitted by parent/guardian to the school/child care facility.

[3]DTP/DTaP: Five (5) doses of DTP/DTaP are required at 4 years of age for school entry unless 4th dose was given on or after the 4th birthday. Interval between dose 4 and dose 5 of DTP/DTaP must be 6 months.

[4]Td/Tdap: Three (3) doses of Td required if primary series started after 7th birthday. If ≥11 years old, one of three doses must be tetanus, diphtheria, and pertussis (Tdap) vaccine dose. Tdap booster required five years after last dose of tetanus, diphtheria-containing vaccine. Td booster required every 10 years.

[5]Tdap: Student must meet the minimum prior requirement for the 4th or 5th doses of DTP/DTaP vaccine and have one (1) dose of Tdap.

[6]Polio: Four doses are required at age 4 for school entry, unless the third dose of an all-IPV or all-OPV schedule is given on or after the 4th birthday, in which only 3 doses are needed. However, if the sequential or mixed IPV/OPV schedule was used, four doses are required to complete the primary series. Polio is not routinely given for students ≥ 18 years of age.

[7]HIB: The number of primary doses is determined by vaccine product and age the series begins. The last dose of Hib must be administered on or after 12 months of age, however, if only one (1) dose is given, it must be administered on or after 15 months of age. The vaccine is not required for students 5 years of age and older.

[8]MMR: Second dose required at 4 years of age. First dose must be given on or after the first birthday. Second dose may be given one month after the first dose. MMR and Varicella must be given on the same day or separated by 28 days.

[9]Varicella: Second dose required at 4 years of age. First dose must be given on or after the first birthday. If first dose given between 12 months and 12 years of age, second dose is given 3 months after first dose; if first dose is given at ≥ 13 years, 2nd dose may be given one month after first dose. The Varicella vaccine is not required for a student who has a history of chickenpox verified by a primary care provider and includes the month and year of disease.

[10]Hepatitis B: If monovalent hepatitis B vaccine is given in conjunction with a combination vaccine, i.e. DTaP-IPV-Hepatitis B, four doses of hepatitis B is acceptable; however, dose 3 or 4 must be given at age 24 weeks or later and at least 8 weeks after the previous dose. If monovalent hepatitis B vaccine is administered, dose 3 must be given at least 16 weeks after dose one and at least 8 weeks after dose 2. For students 11-15 years old, a clearly documented 2-dose adult hepatitis B vaccine (Recombivax) is acceptable.

[11]Hepatitis A: Required for students born on or after January 1, 2005.

[12]Pneumococcal: The number of pneumococcal doses required depends on the student's current age and the age when the first dose was administered. Administer 1 dose to healthy children aged 24 through 59 months who are not completely vaccinated for their age. The vaccine is not required for students 5 years of age and older.

[13]Meningococcal: Required at age 11 years of age and older.

[14]HPV: Required for students entering the sixth grade for the first time. Information concerning human papillomavirus (HPV) and the HPV vaccine must be provided to parent/guardian or student. A parent/guardian may sign a form approved by the Department of Health to "Opt-Out".

Section 2: Medical Exemption – Complete this section if there exist a medical contraindication which prevents the child from receiving one or more immunizations in a timely manner consistent with D.C. Law 3-20 & ACIP recommendations. Check all contraindicated vaccines and provide a reason for contraindication. If the medical exemption is permanent, check appropriate space. If medical exemption is temporary, check the appropriate space and enter the date it expires. Medical provider must sign, print name or stamp and date this section.

Section 3: Alternative Proof of Immunity – Complete this section if blood titers are used to show proof of immunity. Check vaccine(s) which blood titer were obtained. Attach a copy of the titer results. Medical provider must sign, print name or stamp and date this section.

Government of the District of Columbia
Vincent C. Gray, Mayor

District of Columbia Immunization Requirements[1]
School Year 2013 – 2014

DEPARTMENT OF HEALTH
Promote. Prevent. Protect.

All students attending school in the District of Columbia must present proof of appropriately spaced immunizations by the first day of school.

A child 2 years or older entering Preschool or Head Start

- **4** Diphtheria/Tetanus/Pertussis (DTaP)
- **3** Polio
- **1** Varicella (chickenpox) – if no history of disease[2]
- **1** Measles, Mumps & Rubella (MMR)
- **3** Hepatitis B
- **2** Hepatitis A
- **3** or **4** Hib (Haemophilus Influenza Type B)[3]
- **4** PCV (Pneumococcal)

A student 4 years old entering Pre-Kindergarten

- **5** Diphtheria/Tetanus/Pertussis (DTaP)
- **4** Polio
- **2** Varicella (chickenpox) – if no history of disease[2]
- **2** Measles, Mumps & Rubella (MMR)
- **3** Hepatitis B
- **2** Hepatitis A
- **3** or **4** Hib (Haemophilus Influenza Type B)[3]
- **4** PCV (Pneumococcal)

A student 5 – 10 years old entering Kindergarten through Fifth Grade

- **5** Diphtheria/Tetanus/Pertussis (DTaP)
- **4** Polio
- **2** Varicella (chickenpox) – if no history of disease[2]
- **2** Measles, Mumps & Rubella (MMR)
- **3** Hepatitis B
- **2** Hepatitis A (if born on or after 01/01/05)

A student 11 years & older entering Sixth through 12th Grade

- **5** Diphtheria/Tetanus/Pertussis (DTaP/Td)
- **1** Tdap (if five years since last dose of DTP/DTaP/Td)
- **4** Polio
- **2** Varicella (chickenpox) – if no history of disease[2]
- **2** Measles, Mumps & Rubella (MMR)
- **3** Hepatitis B
- **1** Meningococcal
- **3** Human Papillomavirus Vaccine (HPV) – Students in grades 6 thru 10 or parent may sign approved vaccine refusal form available at www.doh.dc.gov

[1] At all ages and grades, the number of doses required varies by a child's age and how long ago they were vaccinated. Please check with your child's school nurse or health care provider for details.

[2] All Varicella/chickenpox disease histories MUST be verified/diagnosed by a health care provider (MD, NP, PA, RN) and documentation MUST include the month and year of disease.

[3] The number of doses is determined by brand used.

CONFIDENTIAL FORM- SIDE ONE ***Please review instructions on side two***

District of Columbia Oral Health (Dental Provider) Assessment Form

Part 1. Child's Personal Information

Child's Last Name	*Child's First & Middle Name*	*Date of Birth*	*Gender:* ☐ *M* ☐ *F*	*School or Child Care facility:*
Parent/Guardian Name	*Telephone1:* ☐ *Home* ☐ *Cell* ☐ *Work*	*Home Address:*		*Ward*
Emergency Contact:	*Telephone2:* ☐ *Home* ☐ *Cell* ☐ *Work*	*City/State (if other than D.C.)*		*Zip code:*
Race/Ethnicity: ☐ *White Non Hispanic* ☐ *Black Non Hispanic* ☐ *Hispanic* ☐ *Asian or Pacific Islander* ☐ *Other*_____				
Primary Care Provider (Medical):	*Dentist/Dental Provider:*	☐ *Medicaid* ☐ *Private Insurance* ☐ *None* ☐ *Other* _____		

Part 2. Child's Clinical Examination (to be completed by the Dental Provider)

Date of Exam _____

(Please use key to document all findings on line next to each tooth)

Tooth #	Tooth #	Tooth #	Tooth #
1 _____	17 _____	A _____	K _____
2 _____	18 _____	B _____	L _____
3 _____	19 _____	C _____	M _____
4 _____	20 _____	D _____	N _____
5 _____	21 _____	E _____	O _____
6 _____	22 _____	F _____	P _____
7 _____	23 _____	G _____	Q _____
8 _____	24 _____	H _____	R _____
9 _____	25 _____	I _____	S _____
10 _____	26 _____	J _____	T _____
11 _____	27 _____		
12 _____	28 _____		
13 _____	29 _____		
14 _____	30 _____		
15 _____	31 _____		
16 _____	32 _____		

Key (Check Appropriate)

S - Sealants

X - Missing teeth

● Restoration

| Non-restorable/ Extraction

1D-One surface decay

UE- Unerupted Tooth

2D-Two surface decay

3D-Three surface decay

4D-More than three surface decay

Part 3. Clinical Findings and Recommendations (Please indicate in Finding column)

	Findings	Comments
1. Gingival Inflammation	**Y N**	
2. Plaque and/or Calculus	**Y N**	
3. Abnormal Gingival Attachments	**Y N**	
4. Malocclusion	**Y N**	
5. Other (e.g. cleft lip/palate)		
Preventive services completed ☐ Yes ☐ No		

Part 4. Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. **Treatment** ☐ is complete. ☐ is incomplete. Referred to _____		
DDS/DMD Signature	*Print Name*	*Date*
Address		
Phone	Fax	

Part 5. Required Parent/Guardian Signatures

Parent or Guardian Release of Health Information.

I give permission to the signing health examiner or facility to share the health information on this form with my child's school, childcare, camp, or Department of Health

PRINT NAME of parent or guardian	
SIGNATURE of parent or guardian	*Date*

Instructions For Completion of Oral Health Assessment Form: District of Columbia Child Health Certificate

This Form replaces the Dental Appraisal Form used for entry into DC Schools, all Head Start programs, Childcare providers, camps, after school programs, sports or athletic participation, or any other District of Columbia activity requiring a physical examination. The form was developed by the DC Department of Health and follows the American Academy of Pediatric Dentistry (AAPD) Guidelines on Mandatory School-Entrance Oral Health Examinations. AAPD recommends that a child be given an oral health exam within 6 months of eruption of the child's first tooth and no later than his or her first birthday. The DC Department of Health recommends that all children 3 years of age and older have an oral health examination performed by a licensed dentist and have the DC Oral Health Assessment Form completed. This form is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) for the health providers, and the Family Education Rights and Privacy Act (FERPA) for the DC schools and other providers.

General Instructions: Please use black ball point pen when completing this form.

Part 1: Child's Personal Information
Please complete all sections including child's race or ethnicity. Please indicate the ward of your home address. List primary care provider, dental provider, and type of dental insurance coverage. If child has no dental provider and is uninsured, then please write **"None"** in each box. This form will not be complete without **Parent or Guardian** signature in Part 5.

Part 2: **Child's Clinical Examination: Dental Provider: Form must be fully completed. The Universal Tooth Numbering System is used.**
Please use key to document all findings for each tooth. An '**X'** signifies a missing tooth (teeth) with no replacement; non-restorable/extraction; **UE:** unerupted tooth; **S:** Sealants; ● Restoration; **1D:** one surface decay; **2D:** two surface decay; **3D:** three surface decay; **4D:** more then three surface decay

- The Key should be used to designate status for each tooth at time of examination on the Oral Health Assessment Form.
- If a portion of an existing restoration is defective or has recurrent decay, but part of the restoration is intact, the tooth should be classified as a decayed tooth. If one surface has decay, then mark as **1D;** if two surface has decay then mark as **2D**.
- Key **UE:** unerupted, does not apply to a missing primary tooth when a permanent tooth is in a normal eruption pattern.

Part 3: Clinical Findings and Recommendations

- Circle **Yes** or **No** in Findings Column
- For **Yes**, please explain in the Comments Section.

1- Advance periodontal conditions (pockets etc., will be noted under gingival inflammation).
1- Gingival inflammation adjacent to an erupting tooth is **NOT** noted.
1- Inflammation adjacent to orthodontically banded teeth or a dental appliance – whether fixed or removable is noted.
2- Indicate if there is sub and/or supra gingival plaque and or calculus and areas where present.
3- All gingival tissues must be free of inflammation e.g. gingiva is pale pink in color and firm in texture for a finding of 'NO' to be recorded.
3- Frenum attachments labial, sublingual, etc., will be noted under the Abnormal Gingival Attachment Indicator Code if they are the cause of a specific problem- e.g., spacing of central incisors, speech impediment, etc.
4- Status of orthodontic condition should be noted under Malocclusion. Classification of occlusion is: Class I, Class II, Class III, an overbite, over jet, cross-bite or end to end.
5- Other is to be used, together with comments, for conditions such as cleft lip/palate.

- Indicate whether oral health preventive services such as prophylaxis, sealant and or fluoride treatment have been administered.

Part 4. **Final Evaluation/Required Dental Provider Signature**; Indicate whether the child has been appropriately examined and if treatment is complete. If treatment is incomplete refer patient for follow up care. Dentist must s**ign, date, and provide required information.**

Part 5 Required Signatures. This Form Will Not Be Complete Without Parent or Guardian Signature & Date
The parent or guardian must print, sign, and date this part. By signing this section the parent or guardian gives permission to the dentist or facility to share the oral health information on this form with the child's school, childcare, camp, Department of Health, or the entity requesting this document. All information will be kept confidential.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Human Papillomavirus (HPV) Vaccination Opt-Out Certificate

INSTRUCTIONS FOR COMPLETING THIS FORM
Section 1: Enter student information
Section 2: Have parent/guardian or student (if 18 years of age or older) sign and date after reading the HPV Information Statement.

Section 1: Student Information			
Name of School			
Student Name:		Date of Birth:	Grade:
Street Address:	City:	Zip Code:	Phone:
Name and Address of Healthcare Provider:	City:	Zip Code:	Phone:

Beginning in 2009 and in accordance with D.C. Law 17-10 (Human Papillomavirus Vaccinations and Reporting Act of 2007), the parent or legal guardian of a student enrolling in grades 6 through 10 for the first time at a school in the District of Columbia is required to submit certification that the student has:

1. Received the Human Papillomavirus (HPV) vaccine; or
2. Not received the HPV vaccine because:
    a. The parent or guardian has objected in good faith and in writing to the chief official of the school that the vaccination would violate his or her religious beliefs;
    b. The student's physician, his or her representative or the public health authorities has provided the school with written certification that the vaccination is medically inadvisable; or
    c. The parent or legal guardian, in his or her discretion, has elected to opt out of the HPV vaccination program by signing a declaration that the parent or legal guardian has been informed of the HPV vaccination requirement and has elected not to participate.

Section 2: Signatures

Opt-Out for Human Papillomavirus (HPV) Vaccine

I have received and reviewed the information provided on HPV and the benefits of the HPV vaccine in preventing cervical cancer and genital warts if it is given to preteen girls and boys. After being informed of the risk of contracting HPV and the link between HPV and cervical cancer, other cancers and genital warts, I have decided to opt-out of the HPV requirement for the above named student. I know that I may re-address this issue at any time and complete the required vaccinations.

_____ _____
Signature of Parent/Guardian or Student if ≥18 years Date

_____
Print Name of Parent/Guardian or Student if ≥18 years

HUMAN PAPILLOMAVIRUS INFORMATION

Genital human papillomavirus (HPV) is the most common sexually transmitted virus in the United States. There are about 100 types of HPV. Most infections don't cause any symptoms and go away on their own. HPV is important mainly because it can cause cervical cancer in women and several less common types of cancer in both men and women. It can also cause genital warts and warts of the upper respiratory tract. There is no cure for HPV, but the problems it causes can be treated.

About 20 million people in the U.S. are infected, and about 6 million more get infected each year. HPV is usually spread through sexual contact. More than 50% of sexually active men and women are infected with HPV at some time in their lives. Every year in the U.S., about 12,000 women get cervical cancer and 4,000 die from it with rates of cervical cancer in DC being higher than national averages.

HPV vaccine is an inactivated vaccine (not live) which protects against four major types of HPV. These include two types that cause about 70% of cervical cancer and 2 types that cause about 90% of genital warts. HPV vaccine can prevent most genital warts and most cases of cervical cancer.

Protection is expected to be long-lasting. But vaccinated women still need cervical cancer screening because the vaccine does not protect against all HPV types that cause cervical cancer.

HPV vaccine is routinely recommended for girls and boys 11-12 years of age, but may be given as early as age 9 years. It is important for girls and boys to get HPV vaccine before their first sexual contact-because they have not been exposed to HPV. The vaccine protects against some – but not all – types of HPV. However, if female or male is already infected with a type of HPV, the vaccine will not prevent disease from that type. It is still recommended that females and males with HPV get vaccinated. In addition, the HPV vaccine can prevent vaginal and vulvar cancer in females, and genital warts and anal cancer in both males and females.

The vaccine is also recommended for females 13-26 years of age and males 13-21 years of age (or to age 26 in some cases) who did not receive it when they were younger. It may be given with any other vaccines needed.

HPV vaccine is given as a three-dose series:

- **1st Dose: Now**
- **2nd Dose: two months after Dose 1**
- **3rd Dose: six months after Dose 1**

People who have had a life-threatening allergic reaction to yeast, are pregnant, moderate to severe illness should not receive the vaccine. Side effects are mostly mild, including itching, pain, redness at the injection site and a mild to moderate fever.

If additional information is needed, please contact your healthcare provider, the D.C. Department of Health Immunization Program at (202) 576-9342 or the Centers for Disease Control and Prevention (CDC) at 1-800-CDC-INFO (1-800-232-4636).